Automobile Injury Appeal Commission

Province of Saskatchewan

Citation:	*S.M. v. Saskatchewan Government Insurance*, 2007 SKAIA 036
Date:	20070309
File:	158 of 2004

BETWEEN

S.M., Applicant

and

Saskatchewan Government Insurance, Respondent

Appearances*:*
S.M., Applicant
Jane Watson, for the Respondent

Before: **Beverly Cleveland, Chair**
Conrad Hnatiuk, Commission Member
Carol Olson, Commission Member

THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL AND HEALTH INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION

Heard at Regina, Saskatchewan
September 5, 2005

DECISION

[1] The Appellant, S.M., was involved in a vehicle accident on July 14, 2001. Her injuries were initially thought relatively minor but, over time, her complaints became more serious. Eventually, she underwent thoracic surgery on February 9, 2004.

[2] The Appellant applied for and received benefits under Part VIII (the no-fault provisions) of *The Automobile Accident Insurance Act* (the Act). Eventually, SGI terminated her benefits because it was of the view that condition for which the surgery was undertaken was not caused by the vehicle accident.

[3] The Appellant believed that the condition was caused by the vehicle accident and appealed SGI's decision.

FACTS AND FINDINGS

[4] In providing particulars of the Appellant's accident, injuries, medical investigations, treatment and progress in the following paragraphs, we will provide a general overview respecting all injuries. However, as this appeal relates specifically to the alleged injury to her thoracic spine and related complaints, our conclusions do not require details of her other injuries and we will, therefore, focus the following on the alleged thoracic spine injury.

[5] The Appellant was the front seat passenger in a vehicle that entered a flooded city underpass. The vehicle was stalling in waist high water but the driver decided to go on. The Appellant was turned to the right, holding the door handle and watching the water level out the window when the vehicle was struck from behind by another vehicle. She stated in evidence and in a written statement that at the time of the impact, her back was perpendicular to the back seat and was not, therefore, supported by it. Instead, her right shoulder was resting against the side of the headrest. She said that she was in this position when the vehicle was struck from behind and pushed forward about four feet.

[6] The Appellant exited the vehicle through the passenger-side window and walked through the water, up the other side of the underpass. The vehicle met her there and she got in. While shaken by the incident, the Appellant did not immediately notice injuries and proceeded with her errands.

[7] Within an hour, however, the Appellant developed a headache and noticed pain in her right rib area. When she arrived home, she rested in bed for the balance of the day and all of the next as her pain had became progressively worse. The following day, she visited Dr. Resnik, her family physician.

[8] Dr. Resnik reported that he found tenderness in the Appellant's upper back and neck and as well, that she had aggravated a pre-existing condition affecting the Appellant's right wrist. He recommended physiotherapy and prescribed anti-inflammatory drugs. He recommended that the Appellant be off work for three to six weeks while she recovered.

[9] Also on July 23, 2001, the Appellant applied for benefits under Part VIII of the Act. In the part of the application where she was asked to shade the areas of injury on a drawing of a human body, she indicated injuries to her right mid-back to and including her neck, and to her right shoulder, elbow, wrist and thumb. On the portion where she was asked to indicate levels of pain, of the areas listed, she noted headaches and pain to her shoulder, neck, mid-back and arms.

[10] The Appellant attended physiotherapy until late September. It was discontinued at that time because, by then, Dr. Resnik had recommended a secondary assessment as the Appellant's injuries had not resolved in the time anticipated. He also referred the Appellant to a neurosurgeon for further investigation of her injuries.

[11] A report regarding the secondary assessment is dated September 20, 2001. A team of health providers, comprised of a physician, a chiropractor and a physiotherapist, examined the Appellant and diagnosed cervical Whiplash Associated Disorder II and a grade II thoracic spine sprain/strain. The team noted that she also complained of occasional left leg and right facial numbness. The team recommended, among other things, x-rays of

her cervical and thoracic spines, a six to eight week tertiary program and, toward the end of or after the tertiary program, a graduated return to work.

[12] X-rays of the Appellant's cervical and thoracic spines were taken on October 9, 2001. The radiologist reported that he observed a small loose body – perhaps a bone fragment – at C7 and a little narrowing of the disc space at C5-6. No other abnormality was seen on the cervical spine and no abnormality was observed on the thoracic spine.

[13] Dr. Veloso, the neurosurgeon to whom the Appellant had been referred, examined her on October 4 and provided his report on October 10, 2001. He reported that she complained of constant neck and back pain and also, several brief transient episodes of numbness in her left leg. He concluded that her complaints were consistent with cervical and lumbosacral sprains and recommended that she continue in Dr. Resnik's care.

[14] Following these investigations, the Appellant attended to Wascana Rehabilitation Centre (Wascana) for the tertiary program that had been recommended by the secondary assessment team. She underwent a functional rehabilitation assessment at Wascana on October 31 and November 1, 2001 by an interdisciplinary team including a physician, chiropractor, physical therapist, occupational therapist, exercise therapist, psychologist and a nurse. The purpose of this assessment was to confirm the previous diagnosis, assess current status and provide recommendations for on-going treatment and management of the injuries.

[15] That team recorded that the Appellant reported constant pain in her neck, particularly on the right side, and constant pain and tightness through the right shoulder and neck region. Her mid-back was intermittently sore, particularly when she had been sitting for an extended time. She reported pain in her right elbow and wrist. Finally, she reported numbness and tingling in her left leg and buttocks.

[16] The Appellant advised the team that the WAD II and the grade II thoracic sprain/strain were resolving, as was the exacerbation of the pre-existing injury to the right wrist. The Appellant's cervicogenic headaches were improving. The team recommended and eight to 12 week program of tertiary treatment to include stress and pain management

counseling, functional and global fitness conditioning and eventually, a graduated return to work.

[17] Shortly following the functional rehabilitation assessment, Dr. Norman, the physician on the team, recorded her concern that the Appellant continued to complain of significant lumbar and lower thoracic pain and was tender in that area. As no x-ray had been taken of that area, the physician ordered one.

[18] The x-ray, taken on November 23, 2001, showed no abnormality in the thoracolumbar spine.

[19] The Functional Rehabilitation Admission report, dated November 13, 2001, confirmed the assessment team's diagnosis and identified the specific nature of treatments that would be undertaken. In respect of the Appellant's cervical and thoracolumbar spine, the report states: "Biomechanically, the Appellant presented with altered mobility and movement dysfunction of the cervical spine and thoracolumbar spine. Signs of markedly altered right upper limb tension were noted."

[20] On January 9, 2002, Dr. Norman recorded concern about significant lower thoracic and upper lumbar pain that the Appellant reported. She reported severe pain in the area radiating up her lower back when sitting. Apparently all team members had observed that the Appellant had "great difficulty sitting for any length of time". Dr. Norman stated, "Since this finding is so consistent and has been observed by everybody on the team", further investigation was indicated.

[21] A Functional Rehabilitation Program (FRP) progress report from December 14 and 17, 2001 records the Appellant's report that she had experienced a flare-up in the lumbosacral region the week previously and that her right hip was "hiking up" at times. She continued to experience pain when sitting.

[22] As to the flare up, the FRP authors wrote:

> Although movement dysfunction in the thoracolumbar spine has improved, [the Appellant] continues to have considerable pain with sitting and continues to take most of her weight through her hands in unsupported sitting. Thoracic distraction

> provides short-term relief of the symptoms. *[The Appellant] had a flare-up of her right sacroiliac joint last week with obvious signs of altered pelvic position and mobility.* These signs have corrected with treatment over the last week but [the Appellant] continues to feel intermittent tightness in this area at times since this flare-up. [Emphasis ours]

[23] Otherwise, the Appellant was progressing as had been anticipated; she made increases in all areas.

[24] The next FRP progress report, regarding assessment January 14, 17 and 18, 2002, noted that the exercise portion of the program had been adjusted in light of the flare-up and an increase in blood pressure during certain activities. Otherwise, the program had continued as planned. During this reporting period, the Appellant's progress was mixed – she improved in some areas, decreased in some and had no change in others.

[25] As to the problems with her thoracic spine, the team recorded that the Appellant had hypomobility left T10 to 12 and in the lower lumbar spine. Right sacroiliac dysfunction remained due to altered muscle tone in the area. She presented with her right leg rotated while standing. The team recommended an MRI and agreed that she should see an orthopaedic specialist, as Dr. Resnik had by then arranged.

[26] An x-ray of the Appellant's lumbosacral spine taken January 17, 2002, showed no significant abnormality. The MRI taken January 23, 2002, however, showed degenerative disc disease in the upper cervical spine at the C5/6 and C6/7 levels, with some distortion of the cervical cord predominantly at C5/6. There was degenerative disc disease at T7/8 and a very small disc herniation at that level; it did not affect the thoracic cord. Degenerative disc disease was noted as well at T8/9 with a small disc herniation[1]. Finally, the MRI showed a focal right-sided disc herniation at the T10/11 level, causing some distortion of the right side of the thecal sac but no definite distortion of the thoracic cord. The author noted that "This could affect the exiting right T10 nerve root at this level but this is not definite."

[1] The report states that "Again, this does definitely affect the thoracic chord" but by reason of the radiologist's confirmation in his March 10, 2003 report that "As noted previously, these disc bulges do not compress the adjacent spinal cord or nerve roots", we believe that this is a typographical error and that the writer intended to write that it did **not** affect the cord

[27] It may be useful to note Dr. Norman's notation on an undated form that appears to be the request for MRI where she wrote, among other things, that the Appellant suffered pain radiating down her left leg.

[28] Dr. Barron, orthopaedic surgeon, reported on his February 12, 2002 examination of the Appellant. He recorded that she advised of immediate neck pain that subsequently progressed to her mid- and lower back and that radiated into her right buttock and down to her knee. She also reported that the right leg would occasionally go numb from her groin to her toes.

[29] Dr. Barron found tenderness throughout the lumbar spine but full flexion, extension and lateral bending. While she had full rotation to the left, she had no rotation to the right.

[30] Considering his examination and a review of x-rays taken that day and the MRI results, he did not think surgery was indicated. Indeed, he opined that the MRI did not show anything that *could* be treated surgically. He did recommend that she see a neurosurgeon regarding the multiple disc herniations in her cervical and thoracic spines; it appears that these were not within his area of expertise.

[31] Based on Dr. Barron's recommendation, Dr. Norman from the FRP referred the Appellant to Dr. Ekong, a neurosurgeon.

[32] March 12 and May 9, 2002 FRP progress reports record decreased sensation in the Appellant's right leg and that dorsiflexion of the right foot caused sharp sudden pain in her back and right leg. T9 – T12 appeared rotated to the left. The lower thoracic vertebrae were warm to the touch. In the later report, posture changes due to right "quadratus lumborum and iliopsoas spasm" were observed. The Appellant reported severe tenderness from T8 to T11. The condition was reported to be becoming more irritable as flare ups could by then occur with as little as five minutes of sitting. The physiotherapist specifically reported that the benefits of treatment were no longer being maintained.

[33] Dr. Ekong examined the Appellant on May 24, 2002. He reported that the Appellant was in discomfort during the examination. He said that her gait was quite "artificial" and

that she walked with a limp so as to spare her right leg. He observed that her right hip joint was significantly elevated and that she stood and walked with her right leg rotated sideways. Nonetheless, her range of back movement, straight leg raising and sensation were found to be normal and without objective motor weakness.

[34] Dr. Ekong advised that he did not find any "specific objective abnormality". He reviewed the MRI and concluded that it did not show evidence of a "definite disc protrusion in the lumbar region", although there was some evidence of a right T10-11 protrusion. However, he opined that this would not normally cause symptoms in the right leg. He undertook further investigation by arranging an EMG and nerve conduction studies.

[35] Dr. Fink conducted the additional tests that Dr. Ekong had recommended and reported on July 2, 2002. He found that the Appellant held her right hip in a slightly flexed and externally rotated position. She had difficulty walking smoothly. She experienced pain on extension and flexion of her spine, on straight leg raises and on right femoral stretch. His testing, however, disclosed no evidence of peripheral neuropathy or radiculopathy.

[36] Eventually, on July 10, 2002, Dr. Norman reported that the Appellant would be discharged from FRP and to single service physiotherapy (SSPT) where she would have physiotherapy only. This was confirmed in the FRP discharge report dated September 17, 2002.

[37] Following a July 30, 2002 examination, Dr. Barron remained convinced that there was no evidence of neurological impingement in the right leg and no nerve root tension signs. He recommended conservative management as he did not see any surgical remedy. He advised that the Appellant could be as active as she wanted without risk of damaging her back.

[38] At single service physiotherapy, the Appellant's condition was eased considerably but usually for only a day or so.

[39] Eventually, the Appellant was referred to Dr. Buwembo, a neurosurgeon. After examining her on February 15, 2003, he opined that the T10-11 disc prolapse that was, he

said, suspect in the MRI, had likely worsened. He requested a further MRI to confirm or refute his diagnosis.

[40] After receiving a report of the updated MRI, Dr. Buwembo saw the Appellant again on April 2, 2003. He opined that the Appellant's complaints were consistent with a T10-11 disc herniation and the MRI has confirmed that there was a prominent disc herniation at that level. He recommended surgery but the Appellant was reluctant to take that course. Instead, Dr. Buwembo agreed to observe her for a period of six months and then reassess the options.

[41] However, before the six months had passed, the Appellant agreed to undergo the surgery. She testified her pain was, at times, overwhelming and her quality of life was so poor that she felt she had no options left. Dr. Buwembo advised SGI of her decision in a letter dated May 3, 2003. He admitted to risks associated with the surgery but was of the view that the benefits would outweigh the risks. He was satisfied that the surgery would relieve all of the Appellant's symptoms.

[42] On June 4, 2003, Dr. Resnik reported that the Appellant had returned to work but that this had increased her muscle spasm and pain. She then exhibited marked postural deformity. He recommended that she should discontinue working until after her surgery.

[43] It appears that the Appellant's file was then submitted to Dr. Alport, SGI's medical consultant, for review as he wrote to Dr. Buwembo on June 4, 2003.

[44] In this letter, Dr. Alport stated that he did not intend to question Dr. Buwembo's judgment but thought there was information of which Dr. Buwembo might not be aware and that it might influence his opinion. He advised that the impact in the accident was at low speed and that, initially, the Appellant's injuries did not seem severe. He noted that the first MRI was requested due to back and left leg symptoms; the latter could have no relation to the T10 disc protrusion reported. He said that the Appellant only developed right leg symptoms after the MRI and that the right groin location was first identified at the

Appellant's February 2003 visit to Dr. Buwembo.[2] Dr. Alport further suggested that, although the Appellant had complained of back pain throughout the previous two years, the pain complained of was not consistent with a T10 disc protrusion.

[45] Dr. Alport advised that the Appellant had previously seen Drs. Ekong, Veloso, Fink and Barron and that none of them had thought surgery was indicated. He drew Dr. Buwembo's attention to Dr. Fink's conclusion that there was no evidence of radiculopathy.

[46] Dr. Alport advised that reports regarding the previous examinations and tests could be provided if Dr. Buwembo requested. Either way, Dr. Alport wanted to ensure that Dr. Buwembo understood that the Appellant's case was "perhaps more complicated than she might have presented" and, given her history, he questioned the likelihood that the surgery would be successful.

[47] On June 4, 2003, Dr. Alport provided his report to SGI. In a detailed letter, he noted first that the total damage to the vehicle in which the Appellant was riding was minimal. He reviewed the history of the Appellant's complaints, beginning with the pain diagram in her application for benefits and progressing through Dr. Resnik's reports; these, he reported, initially recorded injury to her neck and right shoulder areas.

[48] Dr. Alport next considered the secondary assessment report wherein she was found to have cervicothoracic pain and central thoracolumbar pain, left leg numbness and right-sided facial pain. He noted that the Appellant was observed to sit for over four hours at her secondary assessment; while she reported increased discomfort, the team did not observe any signs of it. That the team's recommendations included only six to eight weeks of treatment, including a graduated return to work, he says, as significant.

[49] Dr. Alport noted that the tertiary assessment essentially confirmed the diagnoses offered at the secondary assessment. In addition, however, he said that the tertiary team identified "significant psychosocial issues". Their recommendation was for ten to 12 weeks of treatment. Notwithstanding recommendations ranging from six to twelve weeks, the

[2] We note this to be inaccurate; right groin affected reported in February 2002

Appellant was treated for 33 weeks before her transfer to SSPT and by this time, her sitting tolerance had been reduced to ten minutes.

[50] Turning to the MRI results, Dr. Alport opined that degenerative changes in the cervical spine and herniations at three levels of the thoracic spine were not clinically significant in relation to the Appellant's symptoms. He further concluded that none of the MRI findings would be a result of the accident.

[51] Dr. Alport was of the view that the only question arising from the MRI was whether the T10-11 disc herniation was affecting the right T10 nerve root. He concluded that the Appellant's symptoms were inconsistent with a conclusion that it did because the T10 nerve root would not affect the left leg.

[52] Dr. Alport concluded that the three small disc herniations in the lower thoracic spine were unrelated to the vehicle accident for two reasons: first, the accident was not high impact and, even in her rotated position, the Appellant's back would be protected by the car seat. In any event, a thoracic disc protrusion is an "extremely uncommon" injury in an accident such as she reported; and second, the fact that she has degenerative disc disease of the lower cervical and in several lumbar vertebrae indicate a general degenerative process and not an isolated traumatic injury.

[53] Dr. Alport considered the reports of Drs. Veloso, Barron, Ekong and Fink. He noted that none of them had achieved findings that would indicate a T10 radicular pain syndrome and no surgical pathology. In at least Dr. Ekong's case, Dr. Alport thought that Dr. Ekong had concluded that a T10 disc protrusion would not cause the symptoms of which the Appellant complained.

[54] Dr. Buwembo's report caused Dr. Alport significant concern. He was not certain that Dr. Buwembo had a complete picture, including knowledge of the previous history or of the investigations completed by his colleagues. Dr. Alport believed that the history the Appellant presented to Dr. Buwembo was different than what she had reported previously. Dr. Alport believed that Dr. Buwembo's conclusions were inconsistent with all previous

reports, with accident-related symptoms and with the MRI report that showed no change to the T10 disc herniation.

[55] He summarized his conclusions as follows:

- [the Appellant] did not sustain a T10 disc protrusion at the time of the accident.
- [the Appellant] had soft tissue treatment only at the time of the accident and had had sufficient treatment and time to recover fully from those injuries.
- [the Appellant] had psychosocial problems and/or psycho-logical/psychiatric illness that had contributed to her presentation. Any further investigation and support offered by SGI should be directed toward that.
- [the Appellant] was able to work and should be working.
- There was no clinical indication for thoracic spine surgery and this view is shared by Drs. Veloso, Barron, Ekong and Fink.
- An independent medical examination might be appropriate "for adjudication purposes".

[56] Based on Dr. Alport's recommendation, the Appellant underwent an independent medial examination (IME). The examination was conducted in Calgary, Alberta by Dr. Michael Hunter on July 9, 2003. He reported the Appellant's complaints as follows:

- Pain in the right shoulder and right neck when the hip and pelvis are "out";
- Inability to keep the right leg straight when walking or standing;
- Numbness in both leg[s] with walking a long distance;
- Bladder doesn't empty well when "things are out"; and
- Painful bowel movements when "things are out".

[57] He further reported her complaint that she was unable to sit for more than ten minutes. The Appellant told him that her pain was aggravated with all forms of physical activity and by any form of spinal twisting, particularly rotation to the right. She felt numbness in her legs with walking, but no associated leg weakness. She explained that she obtained some relief by placing all of her weight on her left leg and twisting her right knee and foot outwards.

[58] The Appellant provided a history including the circumstances of the accident and the evolution of her symptoms, including those relating to her "hip going out" sometime apparently between late 2001 and early 2002. She confirmed that her condition was much

worse than it had been in the days immediately following the accident and that it was continuing to worsen as time passed.

[59] On examination, Dr. Hunter found tenderness throughout her thoracic spinal region that was maximal at the T7 level. He found thoracic spinal movements seemed "exquisitely painful in all directions". At the same time, the lumbar spine showed no specific areas of tenderness. He stated that he found the assessment of the lumbar spine and pelvic posture were "confusing and difficult to interpret".

[60] Dr. Hunter reported that all lumbar movement produced pain in the Appellant's low thoracic region on the right.

[61] Dr. Hunter did observe that when the Appellant stood in an anatomically correct position, she had a clear pelvic tilt, with her right hip raised. When she shifted her weight to her left leg, the pelvis evened out. With her right foot turned, she became more comfortable and movements became easier. In this improper position, she could extend and bend to left and right within a normal range. Twisting the lumbar and lower thoracic spines was most aggravating, with right twisting being grossly limited and producing severe pain. In an anatomically correct position, all of these movements were much more limited and much more painful. Significantly, he did not find that her pain radiated in any nerve root distribution.

[62] Dr. Hunter was "completely confused" by the biomechanical aspects of the Appellant's gait and station, though he noted that there were no inconsistent findings. He specifically noted that he could not understand why rotating her right leg influenced her thoracic pain.

[63] Dr. Hunter confirmed that there was no change shown between the January 2002 and March 2003 MRIs. He did note the radiologist's opinion that the T10/11 lesion could "theoretically" involve the right T10 nerve root.

[64] Dr. Hunter attempted to deal with the confusion regarding whether and when the Appellant indicated right and left leg complaints. He found inconsistency in the

documentation and was unable to resolve the matter. He concluded that the situation by then involved both legs and that, in any event, he didn't think the discrepancy was particularly important or that the symptom was very significant because, in his opinion, a symptomatic thoracic disc hernia would not produce leg complaints.

[65] In his conclusions, Dr. Hunter opined that the lower thoracic disc abnormalities were not causing the Appellant's symptoms and he recommended against the surgery that Dr. Buwembo had proposed. On the other hand, he was unable to offer a specific diagnosis and suggested that the Appellant either had a musculoskeletal abnormality that he did not understand or recognize or that there was a major non-organic component to the problem.

[66] He expressly concluded that there was a relationship between the "beginning of this clinical picture" and the vehicle accident. He stated that elements of her pain complex were present immediately after the accident and that they had expanded and worsened with time. Her symptoms continued in some form from the accident to the time of examination. He opined that non-organic factors had magnified and aggravated the symptomology.

[67] Dr. Hunter concluded that the accident did not, however, produce the disc lesions in the lower thoracic area. Nor did he believe that those lesions were totally responsible for the Appellant's symptoms.

[68] He concluded that there was initially a biomechanical disturbance and that psychological factors had magnified and expanded the symptoms. He suggested that psychological evaluation might be advisable.

[69] Finally, on November 16, 2003, Dr. Buwembo responded to the letter Dr. Alport had sent some months earlier. (See paragraphs [44] to [46] above.) Dr. Buwembo noted that, in the accident, the Appellant had sustained a bruise on her abdomen caused by the seatbelt. He suggested that this might give an indication of the forces involved. He seemed unconcerned by the admittedly bizarre multitude of symptoms as her main concern throughout had been the lower thoracic pain; he noted that these had been identified by both Dr. Resnik and the FRP team. He noted that they specifically indicated "hypomobility in the thoracic spine with spasms in the paraspinal muscles and particularly the right

paravertebral spasm in the lower thoracic area." These, he said, therefore, were the focus of his examination and his conclusions.

[70] Dr. Buwembo maintained his opinion that the T10-11 disc hernation was the cause of the Appellant's pain syndrome and that the MRI was consistent with this conclusions. He noted the current and historic difficulty in diagnosing thoracic disc hernias, except with the use of MRIs and that even with MRI confirmation, the difficulty being that even if it causes pain of a radicular pattern, it is sometimes not possible to confirm actual neurological deficits, especially if the disease is not well advanced.

[71] He suggested that while other physicians had not reached his diagnosis, it may have been because they saw her earlier in the progress of her symptoms and were confused by multiples areas of pain, whereas Dr. Buwembo saw her after her pain syndrome had settled.

[72] As to symptoms involving the left leg, Dr. Buwembo agreed that the T10-11 disc herniation would not be the cause but he suggested that lumboscral sprain could cause referred pain to the leg.

[73] Dr. Buwembo listed the reasons he was convinced that the T10-11 disc herniation was the cause of the Appellant's pain as follows:

- The disc is biased to the right, where the pain and muscle spasm were located.
- The pain is of a radicular pattern following the girdle distribution.
- Rotation of the spine aggravated her pain.

[74] In regard to Dr. Hunter's opinion, Dr. Buwembo merely noted that he had not offered an alternative or any diagnosis. He remained of the view that the proposed surgery would be effective and noted that delay has been a major factor in poor surgical outcomes.

[75] Pursuant to Dr. Hunter's recommendation, the Appellant was referred for a mental health assessment on November 20, 2003. This consisted of an intensive examination by a psychologist and a psychiatrist, both of whom reviewed her, by then, very extensive file with SGI. Their report includes their summary of the various document on the file and

details of the results of their examinations and testing. Significant findings in the course of the mental health assessment included:

- A relatively good adaptation to chronic pain, in spite of limited social support;
- No major psychosocial barriers to recovery;
- No significant symptoms of depression;
- No psychosis observed or suggested by psychological tests;
- No evidence of anxiety disorder;
- Minimal but sufficient social support;
- No cognitive deficits;
- Pain reporting that is consistent with the injury reported and that does not appear to involve exaggeration or magnification of her symptoms;
- No personality disorder or personality disorder traits;
- No psychological explanation for the deterioration in her condition; and
- Symptoms appear physical in nature with little evidence to suggest they are of psychiatric origin.

[76] In summary, the mental health assessment concluded that there was no indication of a psychological or psychiatric basis to the Appellant's reporting or experience of her symptoms.

[77] On December 18, 2003, Dr. Alport provided a further report to SGI, having received by then Dr. Buwembo's letter and the mental health assessment report. For the reasons previously provided, Dr. Alport remained convinced that the Appellant's symptoms for which the surgery was proposed, did not result from the vehicle accident on July 14, 2001.

[78] Relying on Dr. Alport's opinion, SGI advised the Appellant by letter dated December 29, 2003 that her benefits would be terminated effective, it appears, the date of the letter with the exception of income replacement benefits which would be paid until January 9, 2004.

[79] Because the letter stated an incorrect section of the Act as the basis for the termination, SGI sent a further letter on January 14, 2004. That letter as well was "replaced" by a letter dated January 26, 2004. The last letter confirmed the termination of benefits.

[80] The Appellant underwent the thoracic discectomy on February 9, 2004. Her recovery from surgery took some months, as anticipated, but was uneventful. She appears to have achieved a full recovery from her symptoms and returned to work.

[81] Further documents were submitted to SGI, including Dr. Buwembo's operative report and a follow-up letter confirming the Appellant's recovery. Upon review, SGI remained of the view that the surgery was not as a result of injuries suffered in the vehicle accident and the termination of benefits was maintained.

[82] The Appellant is the single parent of four children who were 8, 11, 13 and 16 at the time of her accident. Two of the children have significant disabilities, particularly the second youngest who has autism.

[83] The Appellant's injuries, treatment, surgery and recovery caused significant disruption to their home because she was unable to manage housework and child care in the manner she did prior to her injury. [The Appellant's 11 year old son] was particularly disturbed by these disruptions, as it is a symptom of his autism that he relies on routine and is disoriented when that routine is changed; this makes him more difficult to manage.

[84] Housework and child care fell primarily to the Appellant's eldest child, a daughter, during these times. Her daughter testified about additional responsibilities she undertook to help her mother out. Significantly, in anticipation of her mother's hospitalization, she reduced her work hours from full-time to part-time in order to be at home when the other children came home from school. Her daughter testified that during her mother's hospitalization and for a long period of her recuperation, she was almost solely responsible for cooking, cleaning and managing the children. The Appellant's mother helped out by making and bringing supper occasionally or caring for the children from time to time, but it appears that the responsibility fell primarily on her eldest child.

[85] Over time as the Appellant recuperated, she was able to resume more and more of the home responsibilities. By May 2004, the Appellant had fully regained her health and was able to return to work, care for her children, attend to their recreational activities and

manage the household on her own. This was the family's continued circumstance at the time of our hearing.

JURISDICTION

[86] The Commission derives its jurisdiction from section 191(1) of the *Act*, as amended in 2002 and following (the "new *Act*") that provides as follows:

> 191(1) A claimant may appeal a decision of the insurer pursuant to this Part to either the Court of Queen's Bench or the appeal commission within the later of:
>
> (a) 90 days after the date of insurer's written decision; and
>
> (b) if a claimant has requested mediation pursuant to section 190, 60 days after the date the mediator's written statement pursuant to subsection 190(8) declaring that the mediation is completed.

[87] In this case, SGI sent three different letters that might be considered decision letters. The first, dated December 29, 2003, advised that SGI had concluded that the Appellant's symptoms related to a degenerative condition and were not caused by the vehicle accident. The letter advised that no further benefits would be paid and that the last payment would be for income replacement benefits for the period from December 28, 2003 to January 9, 2004. Although the letter does not specify a date that the general termination of benefits would take effect, it appears to be effective the date of the letter.

[88] A second letter was sent to the Appellant on January 14, 2005. This letter corrected an error in the December 29, 2003 letter that had stated an incorrect section of the Act as the basis for SGI's decision to discontinue benefits.

[89] SGI's final letter relating to its decision to terminate the Appellant's benefits was dated January 26, 2004. In this letter, SGI noted that the previous two had contained errors and asked that they be disregarded. The letter further indicated that, in light of the confusion created by the submission of three purported decision letters, the applicable time frame for the Appellant's right to appeal or request mediation would be extended to commence on the date of the third letter.

[90] The Appellant did request mediation of the issues arising from the termination of her benefits. A letter was sent from the mediator to the parties dated September 9, 2004. The Appellant's appeal was filed November 4, 2004 and was therefore within the time frame set out in section 190(1)(b) quoted above. Her appeal is properly before us.

[91] It is therefore unnecessary that we determine which of the three decision letters is operative or the manner of their operation.

ONUS OF PROOF

[92] In the course of argument, a question arose as to which of the parties carried the onus of proof in this hearing.

[93] Counsel for SGI has argued that the onus rests on the Appellant throughout. SGI appears to accept the principle set out in *Collis* v. *Saskatchewan Government Insurance*[3] but says that, in effect, the *Collis* principle did not take effect because the Appellant has not established that she was disabled as a result of the vehicle accident. In written argument, SGI submitted that:

> the termination of payment of Part VIII benefits to the Claimant was undertaken, not because the Respondent was of the belief that the Claimant was no longer in need of benefits, but, rather, because any loss she sustained arose as a result of matters unrelated to the motor vehicle accident. The distinction is critical.

[94] In *Collis*, a decision made in the Saskatchewan Court of Queen's Bench under the same provisions of the Act as bring this matter before this Commission, Justice Wimmer stated[4]:

> Cases dealing with disability insurance contracts hold that the insured has the onus of establishing that he or she is disabled within the meaning of the policy and, having done so, the onus shifts to the insurer to prove that benefits are not, or are no longer, payable. Also, the fact that the insurer at one time accepted the claim may weigh the balance in favour of the insured.

[3] 1998 CanLII 13463, 165 Sask. R. 108
[4] paragraph [5]

[95] The question before us is whether the Appellant has established that she was disabled within the meaning of the policy. If she has not done so, the matter ends. If she has done so, the onus will shift to SGI.

[96] SGI submitted that the Appellant had not demonstrated that her injuries were ever accident-related and that no objective evidence had ever been adduced to establish that they were. While SGI did pay her benefits, it did not do so because the Appellant had met the onus of proof but because SGI thought it appropriate to pay benefits during the time that efforts were being made and investigations taken to establish whether or nor the Appellant was entitled to them.

[97] This argument cannot succeed for two reasons. First, the Appellant did establish that she was injured in the accident and entitled to benefits. SGI has never disputed, and even Dr. Alport did not dispute, that the Appellant suffered at least soft tissue injuries to her neck and back in the vehicle accident. These are injuries as a result of the accident and are, in fact, the injuries in respect of which SGI first commenced paying benefits.

[98] It might be argued, and may have been SGI's intention to argue, that those injuries can be separated from claims respecting the thoracic disc injury; if so, SGI might be taken to argue that the Appellant has not established that *this* injury occurred as a result of the accident. That is, the Appellant established and was paid benefits in respect of soft tissue injuries suffered in the accident. Separately, in effect, she has claimed for the injury to her thoracic spine but has not established causation in that regard.

[99] If so, this argument also fails. The fact is that the Appellant's family doctor diagnosed and consistently reported upper back, neck and arm pain and palpatory tenderness in right thoracic and cervical spines starting two days after the accident, her physiotherapist diagnosed thoracic and lower back pain as early as July 20, 2001. In her Application for Benefits, the Appellant rated mid-back pain at 7 of 10. Thoracic pain was diagnosed at her secondary assessment on October 1, 2001, following examination based on her complaints of cervicothoracic and thoracolumbar pain. Clearly, the Appellant reported and was noted that she had thoracic pain within a very short time after her accident.

[100] It would be kind, for want of a better word, for SGI to provide benefits as a courtesy pending verification of the cause of thoracic pain but we have not been able to find any indication whatsoever in the file documents that SGI questioned causation of thoracic injury until Dr. Alport's (internal) letter June 2003 or, especially, that it advised the Appellant that SGI had doubts about causation and that her benefits might be at risk on that basis.

[101] In considering causation, we must take into account that the Appellant's symptoms evolved and progressed and that she presented increasingly complex symptoms over time. We note, however, that by August 8, 2002, the SSPT intake report concluded that all of the Appellant's symptoms other than her thoracic complaints had essentially resolved. Again, on September 17, 2002, Wascana reported that the Appellant's neck and right shoulder complaints had resolved.

[102] Nonetheless, SGI continued benefits; these cannot after August 8, 2002 have been based solely on the WAD II that SGI has conceded was caused in the accident. Certainly SGI did not indicate at the time or until well into 2003 that it was continuing benefits despite doubts about causation.

[103] The important consideration in this matter is the eventual diagnosis from Dr. Buwembo in April 2003 that the Appellant suffered a T10-11 disc hernia and that this was the cause of her thoracic symptoms. Until SGI received this diagnosis, it had received reports from many health care providers but none had diagnosed the cause of her symptoms. Without a diagnosis, it is difficult or impossible to know whether the diagnosed condition does or might be caused by the vehicle accident. A different diagnosis might have led SGI to conclude that the symptoms must have been caused in the accident. This is why the diagnosis is critical.

[104] Nonetheless, although we recognize the difficulty that the insurer can face in situations like this and while we appreciate SGI's practice of extending benefits until causation is questioned, SGI is bound by the actions it took. In fact, SGI was troubled by the unusual and complex symptoms the Appellant exhibited and by the fact that some were becoming progressively worse despite extensive treatment, but it did not suggest an issue

with causation until Dr. Buwembo's report. Until that time, SGI provided benefits and in particular paid for extensive rehabilitation and investigation of the Appellant's condition.

[105] We are completely satisfied the Appellant established that she was disabled in the July 14, 2001 vehicle accident – whether one looks at her injuries globally or separates the soft tissue injuries from her thoracic complaints – and SGI paid her benefits in regard to that disability. The onus thereafter shifted to SGI and it bears the obligation of establishing on a balance of probabilities that benefits are no longer payable.

[106] Before leaving this subject, we note that counsel referred us to the Saskatchewan Court of Appeal's decision in *Hood* v. *Metropolitan Life Insurance Co.*[5] where the Court considered the onus of proof applicable in a case of total disability for purposes of a disability insurance contract. We are not convinced that the case is applicable in this matter as it considered benefits that had not been paid in regard to an injury that was not accepted as wholly disabling. Further, the court set out three theories as to the nature of the onus but, for reasons specific to that case, did not find it necessary to choose among them. For all of those reasons, it provided no guidance for the case before us.

STANDARD OF REVIEW

[107] As to standard of review, the decision whether an injury was caused in a motor vehicle accident, and therefore attracts benefits under Part VIII of the Act, is not one involving the exercise of discretion. Further, it is a decision that affects a party's entitlement to benefits. That being the case and in accordance with Court of Appeal's decision in *Allary* v. *Saskatchewan Government Insurance*[6], our standard of review in this appeal is correctness.

LAW AND ANALYSIS

[108] This appeal turns on two questions: First, were the Appellant's symptoms caused by a thoracic disc herniation at T10-11? If so, was that condition caused by the vehicle

[5] 17 C.C.L.I. (2d) 205, 109 Sask. R. 130 (C.A.)
[6] 2006 SKAIA 89 (CanLII)

accident? There are two aspects to the second question: did the T10-11 disc herniation occur in the accident or was it the result of treatment for injuries that were caused in the accident?

A. Cause of Symptoms

[109] We are satisfied that the Appellant's symptoms were in fact caused by a T10-11 disc herniation as Dr. Buwembo opined.

[110] The question might have been particularly difficult to answer prior to the Appellant's February 9, 2004 surgery, but it is not difficult now. While all of the health providers who treated or examined the Appellant save Dr. Buwembo were not convinced that the T10-11 disc herniation was the cause of her complaints and some were convinced that it was not, we have the advantage of knowing that the surgery was successful in relieving the Appellant's thoracic symptoms entirely. She testified that she no longer had spasms, headaches or hip rising, her legs were of equal length and that she did not have to rotate her foot. Sitting did not cause pain.

[111] Given her testimony that the relief was immediate after the surgery, and with no evidence from any health provider that the surgery did not relieve the symptoms, there is no other possible or plausible conclusion.

B. Did the Appellant's Vehicle Accident Cause the Disc Herniation?

[112] We are satisfied that the T10-11 disc herniation was caused in the Appellant's July 14, 2001 vehicle accident.

[113] In reaching that conclusion, we are mindful of SGI's assertion that symptoms relating to the T10-11 disc hernation were not reported until six months after the accident. We cannot accept this submission. In fact, as is noted in paragraph [100] above, thoracic complaints were identified and diagnosed as early as July 20, 2001 and are consistent, though worsening, thereafter.

[114] We have also considered the opinions to the effect that a herniation of this nature is unlikely in a low-impact vehicle accident.

[115] However, we note that this accident involved vehicles that were in a significant depth of water – almost to the windows or waist level, as the Appellant has recounted at different times and she was forced to exit the vehicle through the passenger window. No one qualified in accident reconstruction testified before us as to the nature of impact in a low-speed rear end collision in general or, specifically, as to those that occur in unusual conditions as this accident did. We can take notice of the fact that a low-impact accident will usually not produce serious injuries but we are also mindful that it can. Further, we cannot draw conclusions as to the impact that the depth of water might have had but we can and do conclude that it may have had an impact.

[116] Accepting medical opinions that were provided that a low-impact accident is unlikely to cause an injury of this nature, we are impressed by Dr. Buwembo's observation that the bruise to the Appellant's abdomen (to which the Appellant also testified) suggested that the impact might have been greater than others may have assumed; it must be taken to indicate some significance of impact.

[117] Dr. Alport is the only other person who specifically spoke to the likelihood of a T10-11 disc herniation being caused in an accident of this nature. However, we believe that his opinion is based on inaccurate assumptions.

[118] While he conceded that such an injury can be caused in a low-impact accident, he thought it unlikely in this case, particularly as the Appellant's back would be protected by the seat back. While he acknowledged that the Appellant's body may have been rotated at the time of impact – and he provided no reason why he did not accept her evidence that it was – he opined that it would nonetheless have some protection from the seat back.

[119] On the other hand, the Appellant testified and has maintained since the day of the accident that, at the moment of impact, her body was entirely rotated as she looked out the car window and her back was perpendicular to the seat. She says that it was not supported by the seat back, though her right shoulder rested against the seat's headrest. We accept her

evidence in this regard and have concluded that the Appellant's back was not protected by the car seat back at the time of impact.

[120] Second, Dr. Alport relied on MRI findings that the Appellant had degenerative disc disease in her cervical and lumbar spines and that these are clearly not related to the vehicle accident. He opined that the T10-11 disc herniation was part of the degenerative disease and not "an isolated traumatic injury".

[121] We do not take issue with Dr. Alport's statement that the degenerative disc disease was not related to the vehicle accident but we are not satisfied that his conclusion that the T10-11 disc herniation was necessarily part of the degenerative process. Even a person with degenerative disc disease can suffer a traumatic injury to his or her spine. We speculate, without relying on the speculation, that a person with degenerative disc disease might be more susceptible to traumatic back injury.

[122] The Appellant testified that she had not suffered any back problems at all prior to the accident, nor had she suffered symptoms similar to those she later complained of affecting her hips, leg and pelvis. At the same time, she complained of mid-back pain within days of the accident. While we don't dispute Dr. Alport's view that a T10-11 condition might be part of a degenerative process in a spine such as the Appellant's, we think it too unlikely and coincidental to conclude that in this case and these circumstances an essentially pre-existing and non-symptomatic condition spontaneously developed a T10-11 hernation concurrently with traumatic impact – whatever its velocity.

[123] Even if we are wrong in that conclusion, we would nonetheless conclude that the T10-11 disc herniation was caused by the accident for legal purposes. In this regard, we are mindful of the Court of Queen's Bench decision in *Deibert* v. *Giddings*[7] which deals with injuries caused in the course of treating injuries sustained in an accident.

[124] There is evidence which might suggest that the Appellant's T10-11 disc herniation occurred in the course of her tertiary treatment. Throughout that treatment, the Appellant attended for full-days, five days per week. She participated in physiotherapy, exercise

[7] 2003 SKQB 533 (CanLII), 242 Sask. R. 184

therapy and a conditioning program; all of these involved the use or manipulation of her body.

[125] The Appellant testified that on the morning of December 8, 2001, she woke to find her body in full spasm. This, she said, is the first time this happened but certainly not the last and that following this "strange things started happening". When in spasm, her right hip was raised and her right leg would rise; it was very painful. She was in full spasm when she attended for the IME (after having sat on the airplane) and her condition was observed by Dr. Hunter.

[126] In addition, it was observed, treated and documented by all practitioners at the FRP. In its first report after December 8, 2001, the team reported (as is also quoted in the factual portion above) that she had "a flare-up of her right sacroiliac joint last week with obvious signed of altered pelvic position and mobility." Further comments on the observation and treatment of this condition are plentiful in the team's subsequent reports.

[127] The Appellant testified that on the day previous, she had been given a new treatment at FRP that she described as a "suction cup machine". She thought that this might have caused the spasm but volunteered in her testimony that Dr. Buwembo said that it would not be the cause.

[128] We therefore do not have direct evidence that on-going treatment or any specific part thereof caused the T10-11 disc herniation.

[129] Nonetheless, we can come to no other conclusion, if the T10-11 injury was not caused by the accident, that it must have been caused in some manner in the course of treatment – either as a result of a specific activity or as a result of the global impact of the treatment. There is simply no evidence of any other activity or incident that might have caused the condition. As is noted above, we are not able to accept the condition as purely coincidental or spontaneous in these circumstances.

[130] That being the case, had we not concluded that the T10-11 disc herniation was caused in the accident on July 14, 2001, we would have concluded, in accordance with

Deibert v. *Giddings*, that the condition being caused in the course of treatment was "a reasonably foreseeable consequence of accepted treatment for the type of injuries[8]" the Appellant sustained in the vehicle accident.

[131] The above case was decided based on the principles of tort law and the approach to reasonable foreseeability in the tort context is well embedded therein. While SGI, under the statutory no-fault system is not a wrong-doer or "tort feasor", we have stated previously in *A.I. v. SGI*[9] that SGI should bear the responsibility for injuries suffered by a customer while participating in a form of treatment, where the risk of medical error or misadventure is reasonably foreseeable and not too remote.

MISECLLANEOUS MATTERS

[132] A great deal of consternation has been caused to some practitioners who examined the Appellant and/or her documented history as a result of the fact that on some occasions earlier in her care, certain of her complaints were indicated to involve her left leg, while later reports refer to her right leg being affected. Dr. Norman, for example, made reference to the Appellant's left leg when she made the referral to Dr. Veloso but stated in a later report that the Appellant had had problems with her right leg since December 8, 2001.

[133] Dr. Hunter recognized the discrepancy and offered an explanation for how it might have occurred. He eventually concluded that it was unimportant. We are also inclined to that view. What is important is that by the time SGI was concerned about causation and referred the Appellant for further investigation by way of IME and a mental health assessment, the only leg complaints involved were to her right leg.

[134] Either the references to the left leg were erroneous or the Appellant had symptoms in her left leg at one time and in her right eventually. This is not to say that the symptoms moved from one leg to the other, an unlikely occurrence to our understanding. Given the complexity of her symptoms, the possibility that the Appellant had left leg complaints at one

[8] Paragraph [27]
[9] 2004 SKAIA 018 – paragraphs [17] – [19]

time and right leg complaints at another is not difficult to accept. Neither is the Appellant's evidence that she complained of right leg symptoms throughout.

[135] Another matter that requires comment is the suggestion, from Dr. Hunter and Dr. Alport, that the Appellant's symptoms were affected by psychological or psychiatric problems. While theoretically accepted as health concerns like any others, the fact is that such suggestions can carry an element of stigma and embarrassment. We note that in our review of the evidence, we found no suggestion that the Appellant suffered any psychological or psychiatric difficulties, that she exaggerated or magnified her symptoms, that she was pain-focused or attention-seeking, that she gave less than full effort to her treatment and care or that she was for any reason not motivated to recover. Instead, she moved forward despite frustrating years without a diagnosis and underwent serious surgery in the face of multiple opinions that advised against it. Much to her credit, the Appellant showed a generally positive attitude and tenacity and courage throughout.

CONCLUSION

[136] We are satisfied that the Appellant's T10-11 disc herniation was caused by her vehicle accident on July 14, 2001 and that SGI's decision that it was not so caused was in error. As a result, SGI's decision to terminate income replacement benefits effective January 9, 2004 and other benefits effective December 29, 2003 is set aside.

[137] The Appellant shall be paid all benefits, together with pre-judgment interest, to which she was entitled including, without limiting the foregoing:

1. income replacement benefits from January 10, 2004 until the date of the Appellant's return to work;
2. living assistance benefits for the period from the date of surgery until the Appellant was able to resume activities of daily living, including child care, housekeeping and heavy housework, including yard care;
3. recommended and prescribed medications for the period from December 29, 2003 until the Appellant's recovery from surgery no longer necessitated them;

4. any other benefits that would have been appropriate, had the decision to terminate benefits not been made including, if appropriate, benefits for permanent impairment.

[138] In regard to each aspect of benefits set out above, SGI shall provide details of its calculations and a decision sufficient to generate the Appellant's right of appeal.

COSTS

[139] As the Appellant has been successful in her appeal, she shall be reimbursed her reasonable costs and expenses in accordance with section 193(11) of the Act and section 96(1) of *The Personal Injury Benefits Regulations*, to a maximum of $2500.00.

[140] In addition, the Appellant's appeal fee shall be refunded.

Dated at Regina, Saskatchewan, on March 9, 2007.

Beverly Cleveland, Chair

Conrad Hnatiuk, Commission Member

Carol Olson, Commission Member